

Taming the “Lockbox”

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The thought of having to develop a fully functional lockbox is creating a lot of angst for a lot of Ontario hospitals. The lockbox is law. Common law principles that address personal health information in Ontario are now codified to a large extent. The bulk of these now fall under the *Health Information Protection Act*, the statute that includes the *Personal Health Information Protection Act (PHIPA)* and the *Quality of Care Information Protection Act (QCIPA)*. Public hospitals were granted a one year “grace period” to comply with the lockbox provisions of the legislation. That grace period has expired.

The term “lockbox”, not defined in *PHIPA*, refers to hospitals’ attempts to give effect to patients’ instructions not to use or disclose to specified persons their personal health information (PHI) for healthcare purposes without consent. Patients may withhold or withdraw this consent. Attempting to translate lockbox law into hospital policy and procedure presents many challenges, some to be discussed below.

Translating Lockbox Law into Hospital System: Factors to Consider:

How can you ensure legislative compliance and minimal risk as you comply with lockbox provisions? Developing your system involves several steps that can be envisioned as follows: planning, initiating, implementing and controlling the design of the system. In planning, you consult best practice guidelines to ascertain clearly defined goals and to plan your approach, including the scope and timeframes you wish to adhere to and the risk you will accept. Planning allows for control; any feature not planned for becomes either a scope creep or a risk event. During your initiation phase, various tools (incident reports, accreditation results, etc.) can be employed to help you assess your current PHI-related documents and practice, as you conduct a gap analysis to identify inconsistencies and the legal risks they present. Tools, such as a risk rating matrix, may be used to design the plan. The plan should include: legally compliant and professionally workable strategy and process that can live into the future (e.g., in the event of legislative change); and policy documents and associated templates that incorporate your strategy and process. The next phase is implementation, in which you pilot your plan in what is essentially its first test, and then roll it out strategically on a staged basis, revising as necessary. Controlling involves ongoing monitoring and evaluation to ensure

that your goals, initial and changed, are met. There are many decision points throughout this process.

The major challenge is translating lockbox law into policy and procedure is to design a process with the requisite capabilities. Putting the lockbox process in place involves implementing a number of measures that can be broken down roughly into three areas: physical, organizational and technological. Physical methods involve a range of items from locking drawers to managing remote access. Organizational measures may range from establishing security clearances to providing information on a “need to know” basis. Technologically, hospitals are looking at measures such as passwords and database linkage with its ability to transfer PHI. These types of measures are increasingly important in this era of hospital amalgamations and LHINs.

Many questions need to be considered, among them: Who should have access to PHI? To what extent? How do they obtain access? Where do agents and recipients fit in? Who decides? What happens when staff change jobs to work in other programs or sites? What about ensuring that PHI is not visible to those who do not need it to provide care? Do patients realize that locking their chart may cause treatment delays (though not always)? Do they understand that locks must be overridden in some circumstances? What method will you use to inform them? How do you manage breach? Who is accountable, and what are the lines of response? In sum, what are the best practices to follow?

While I have considered some of the fundamental elements required to tame the lockbox, many others are necessarily beyond the scope of this brief essay. Let me finish with some further very critical elements: to develop an effective comprehensive lockbox system requires commitment from senior executives and the Board, buy-in from the staff, built-in accountability and clear lines of communication.

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